Combat/Operational Stress, Behavioral Healthcare, and the PDHRA

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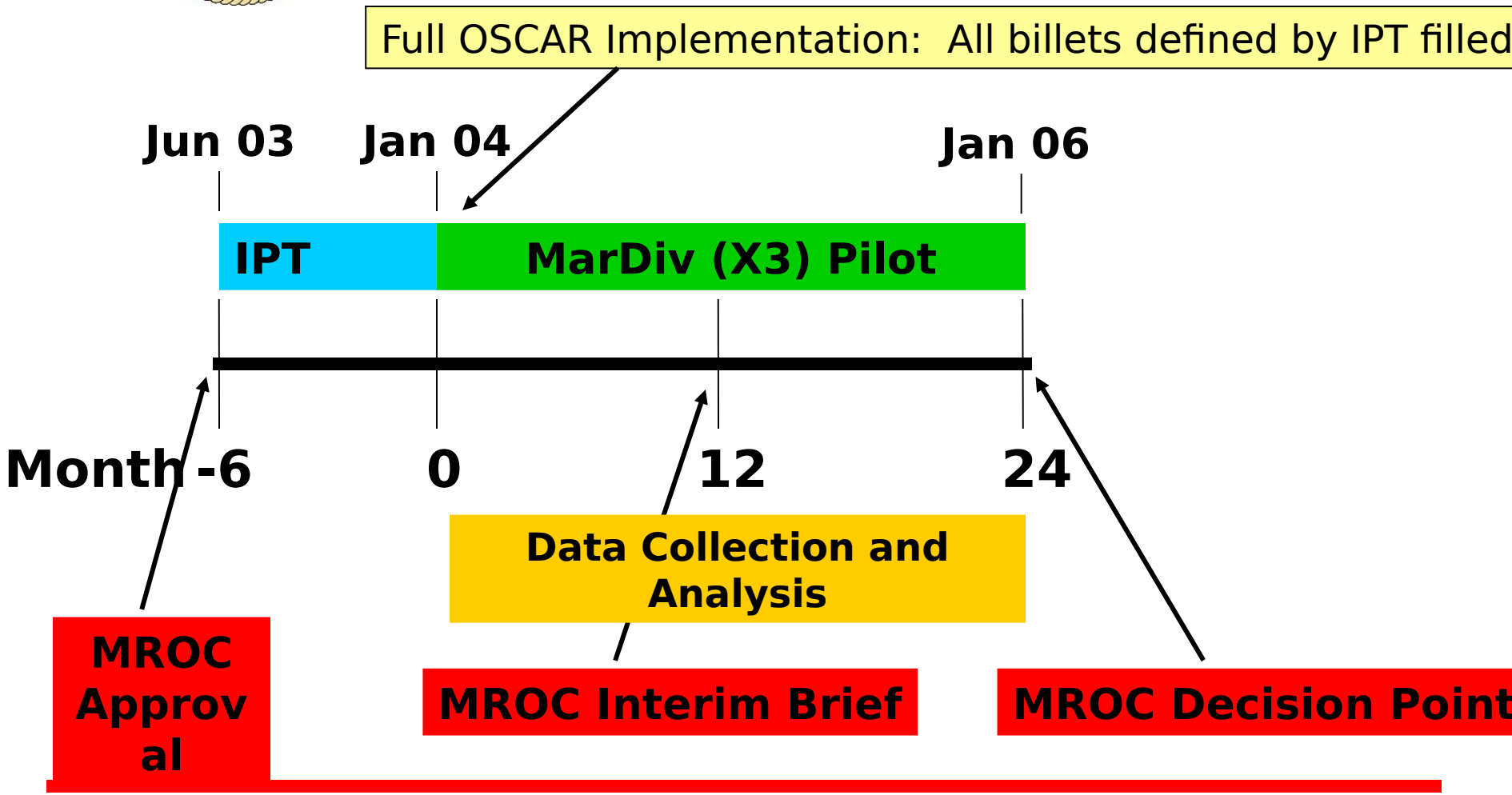
Overview

- The Problem
- OSCAR
- Findings From EFCAT Mission & IG Assist Visit
- PDHRA
- The Way Ahead

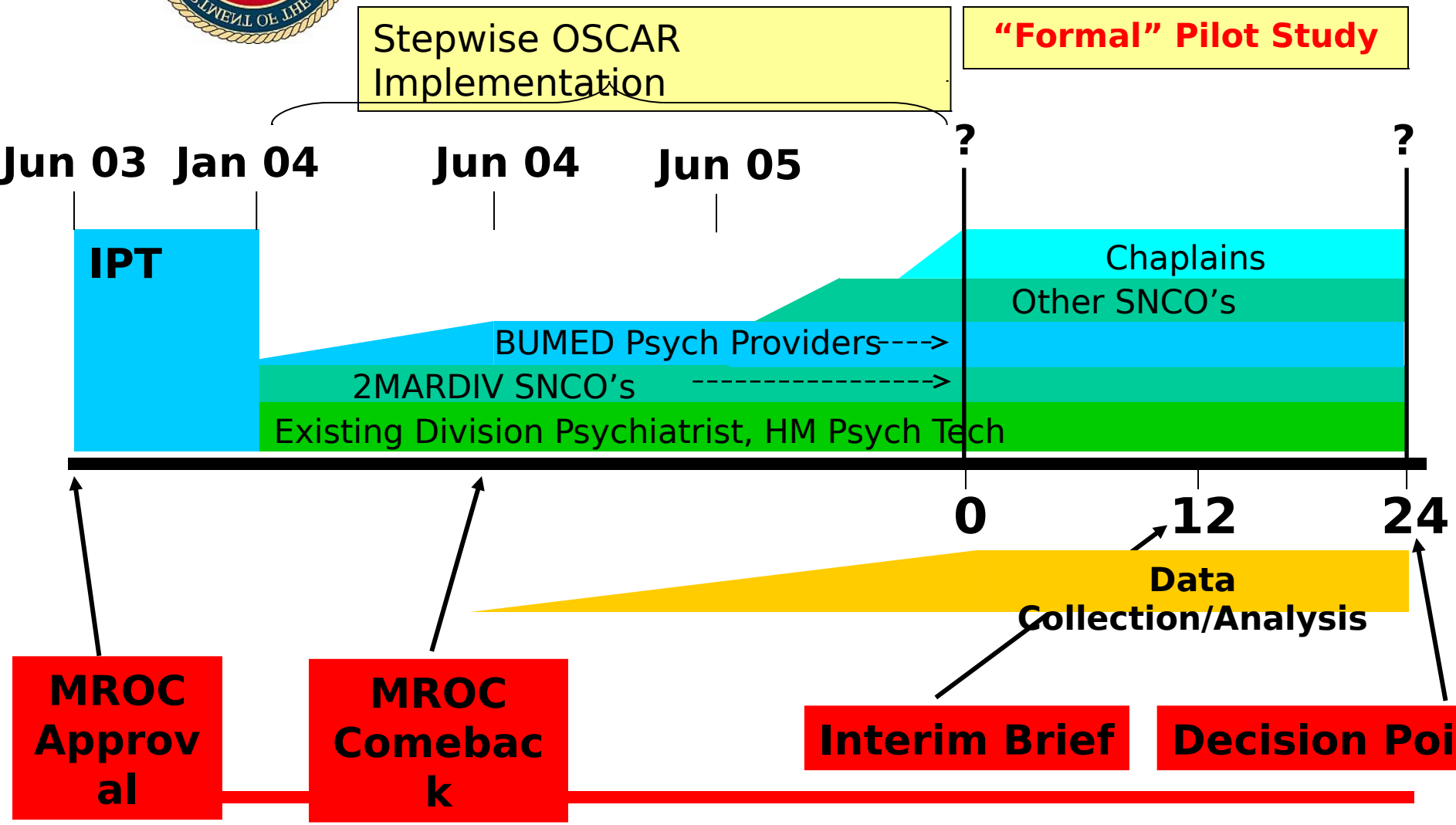
The Problem

- High incidence of stress and bona fide psychiatric illness in the wake of deployment
- Stigma interferes with seeking care
- Inadequate mental health capacity at MTF's serving Marines
- Inadequate HQMC coordination, doctrine

OSCAR: Original Timeline



OSCAR: Actual Timeline



OSCAR Validation

- Partial implementation is already showing results. Preliminary data show:
  - Lower med-evac rate for GCE versus FSSG and ACE in theater (data on next slide)
  - Within-unit support transcends stigma
  - Battalion commanders have greater trust & confidence in their “embedded” psych experts
- Psych augmentees deployed with Medical BN’s are being employed in an “OSCAR-like” fashion
- CNA to study OSCAR outcomes & its potential applicability to the reserves

Findings from EFCAT mission and IG Assist Visit

- Mental health/chaplain cooperation better now
- Commanders like & trust OSCAR
- MAP personnel ignorant of particular role of battlefield stress management
- Ambiguous policy guidance from HQMC leading to variations in execution
- USMC leaders want a “wrap-around” approach
- Need/desire to push stress management “downward” to the platoon level

Post-Deployment Health Reassessment (PDHRA)

- Post-DHA misses people in need
  - Underreporting
  - Delayed emergence of symptoms
- Reassess Post-DHA completers at the 3-6 month mark
  - If deployed prior to March 04, optional, passive
  - If deployed after March 04, required, active
- All-electronic
- AMSA is data repository

PDHRA Implementation Issues

- Difficult notification process; ownership unclear
- Delays in funding to NEHC for ePDHRA
- “Road show” needed to survey drilling reservists
- Results of I MEF pilot
  - Time-consuming for providers & Marines
    - Screening of all Marines back from OIF will take many months
    - Expect over 1000 psych consults which will overwhelm clinics
  - Recommend a PDHRA administration team and significant augmentation of hospital mental health clinic
  - Web-based administration essential

Next Steps

- Hire, train PDHRA program managers
- Decide on next steps in implementation
  - Larger pilot
  - Navy- and Marine Corps-wide
- Calculate new estimates for roll-out date(s)
- Work with ASD/HA to hire
  - “Road show” screening personnel
  - More mental health staff

Way Ahead

- OSCAR
  - CNA study
  - Review feasibility of filling SNCO and Chaplain billets
  - Consider applicability of concept for other MSC's, Reserve
- New Combat/Operational Stress Control Section at HQMC (M&RA)
  - CAPT Nash to lead
  - Multidisciplinary COSC Advisory Board
  - Mission: develop a wrap-around stress management program incorporating OSCAR, Warrior Transition, MCCS, MTF mental health
- Navy Medicine COSC Advisory Board
- TECOM's mentorship program

- Questions?
- Comment

Back-Up Slides: The Problem

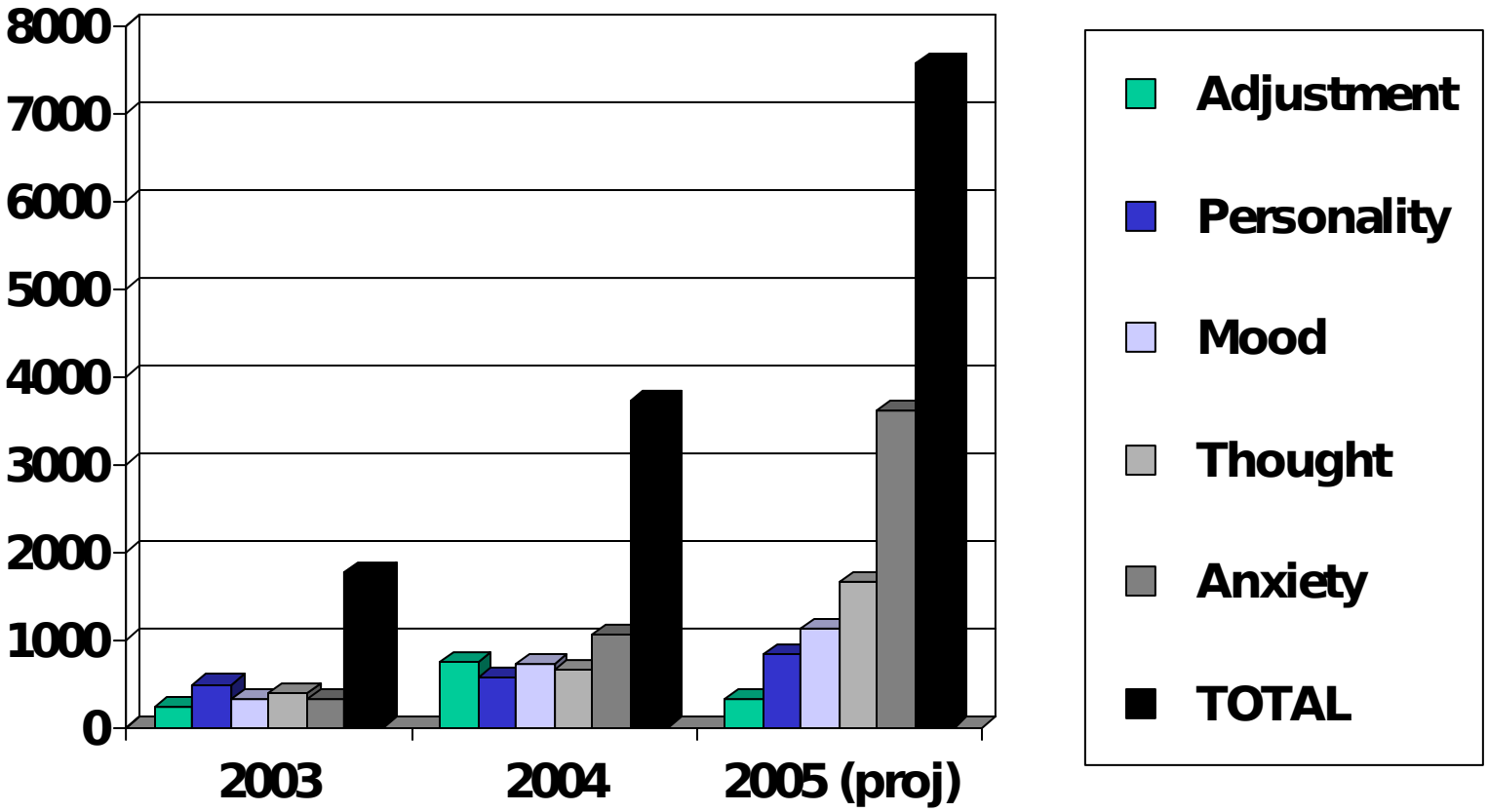
The Issues

- 15% of Marines back from OIF-I met screening criteria for disabling depression, anxiety, and/or PTSD
- Post-deployment stress associated with
  - Family disruption, separation, divorce, domestic violence
  - Accidents, misconduct, suicide (up 28%)
  - Administrative Separation, Physical Disability
- Recruitment/retention an emerging issue

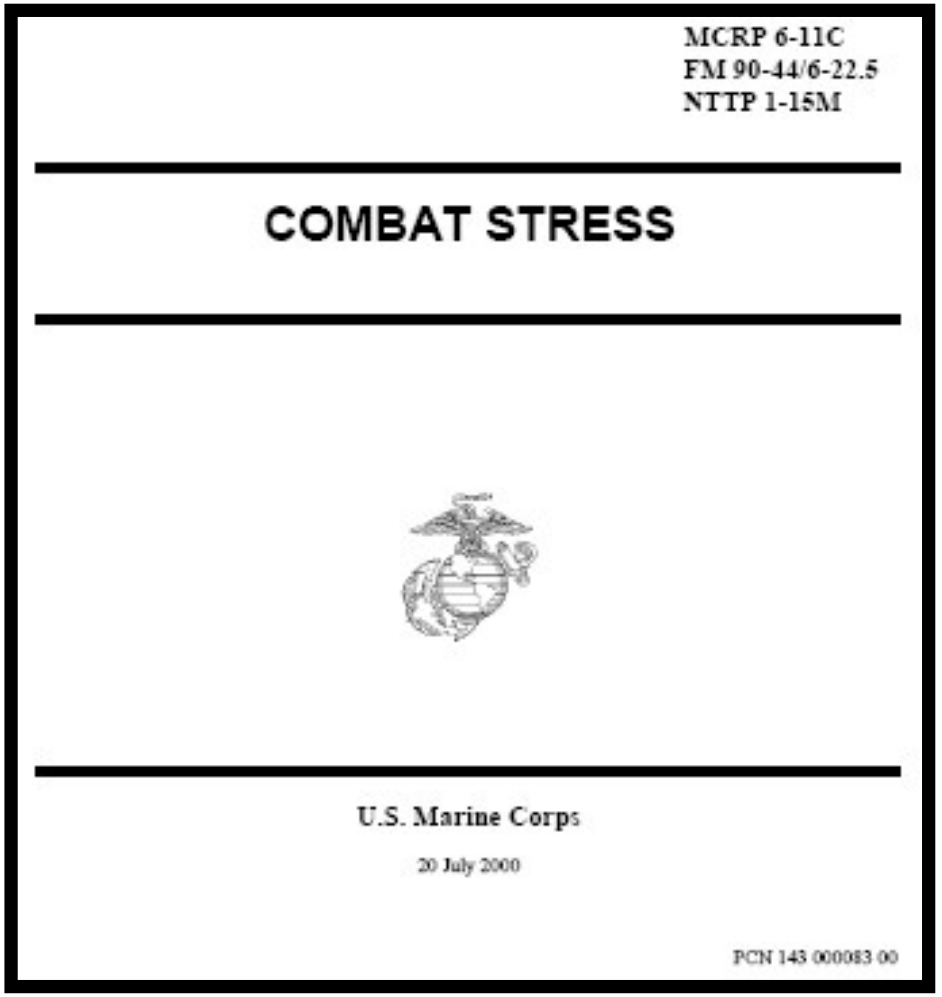
Stigma, Poor Access to Care

Control office

Mental Health Visits at NH CPen



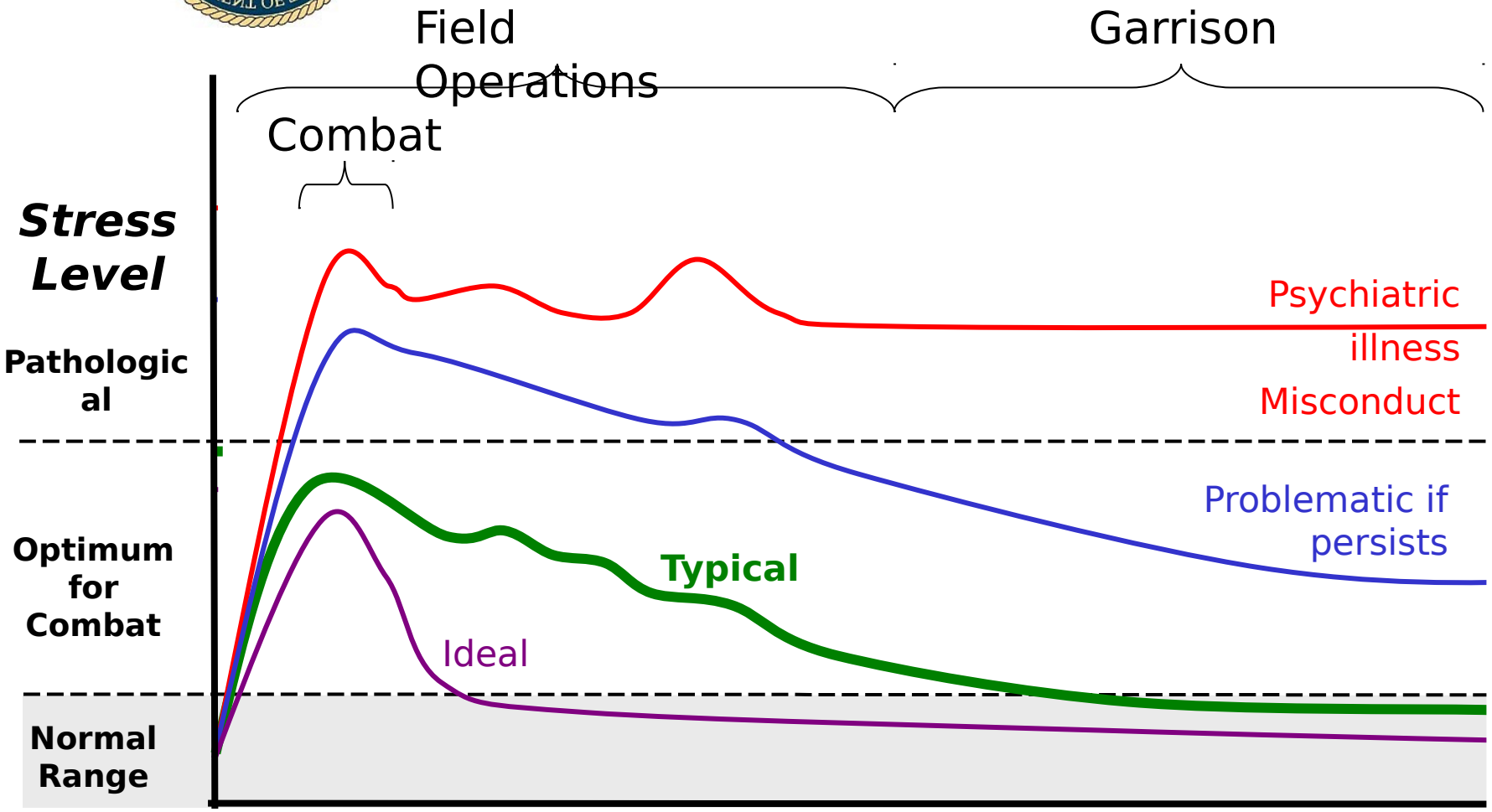
- COSC doctrine: feast or famine
  - Army: 281 page field manual
  - USMC: reference publication and local TTP's



Warrior Transition

- Chaplain-centric program in OIF-I & II
- Working Group to Update It
  - Collaboration: line, chaplains, and mental health
  - Three-stage educational effort
    - Mental health and core group of Chaplains to unit chaplains
    - Unit chaplains to small unit leaders
    - Small unit leaders to rank and file Marines
  - Three phases
    - Warrior Preparation
    - Warrior Sustainment
    - Warrior Return

Stress Patterns Amongst Expeditionary Warfighters



Various Approaches to Stress Prevention/Management

- Character Development
  - Toughness; force of will
  - Inadequate; stigmatizes those with problems
- Education
  - Teach accurate expectations and self-care
  - Inadequate
- Peer-to-Peer Support/Mentoring
  - Ubiquitous; credible
  - May exceed skill set; problems if “peer” is traumatized also

Various Approaches to Stress Prevention/Management

- Pastoral Care
  - Memorial services; individual/group teaching, counseling
  - Cultural divide, often exceeds typical skill set
- Psychological Debriefing
  - Review event(s) and emotionally ventilate
  - May not work; counterproductive if re-traumatization likely; may interfere with chain of command
- Medical Model
  - Diagnose and treat individuals who are abnormal
  - Inadequate prevention; cultural divide; inadequate access to care; ***stigma***

Air Force Approach

- Efforts are not deployment- or incident-focused
  - Short deployments; only 1% of force in direct combat; minimal PTSD
  - Well-demarcated incidents, mostly aircraft mishaps
  - No need for organic mental health or chaplains
- Instead, uses a systematic community effort
- Each organizational level of the USAF features two coordinating bodies:
  - Community Action Information Board (CAIB)
  - Integrated Delivery System (IDS)

Air Force Approach

- Leadership roles in event of an incident
  - Lead, intervene, seek assistance from base resources
  - Guidance provided by online *Leader's Guide To Personnel In Distress*
  - 30 hours of stress management education (classroom, online) annually for leaders and rank-and-file
- Stress Management Provider Roles
  - Mental health teams intervene/deploy if requested
  - No longer conducting psychological debriefings

USAF versus USMC

- Agencies and services are coordinated better – at both the headquarters and installation levels
- Doctrine is more extensive; guidance for leaders is clearer
- USAF has approx 50% more mental health personnel than USN/USMC
- USAF has less integration of stress management providers with warfighters

Validation & Incorporation Into USMC

Early/Expeditionary Intervention

- Self- and Buddy-Aid
  - Lessons from psychological debriefing
  - Role of USMC training continuum
- Leadership
- Increased role of line corpsmen, BAS
  - Requires training
- Increased effectiveness of chaplains
  - Training, collaboration with mental health
- Avoidance of mental health stigma by…
  - “Embedding” mental health, e.g. the OSCAR program
  - Use of Marine SNCO’s as part of stress teams

Validation & Incorporation Into USMC

Ongoing and Post-Deployment

- Organizational improvements
  - Wrap-around doctrine
  - USMC champion at HQMC
  - HQMC and installation coordinating bodies
- Unit cohesion as primary method
- Community health approach in support of small unit leadership
- Consider increased footprint of well-trained organic mental health

Back-Up Slides: OSCAR

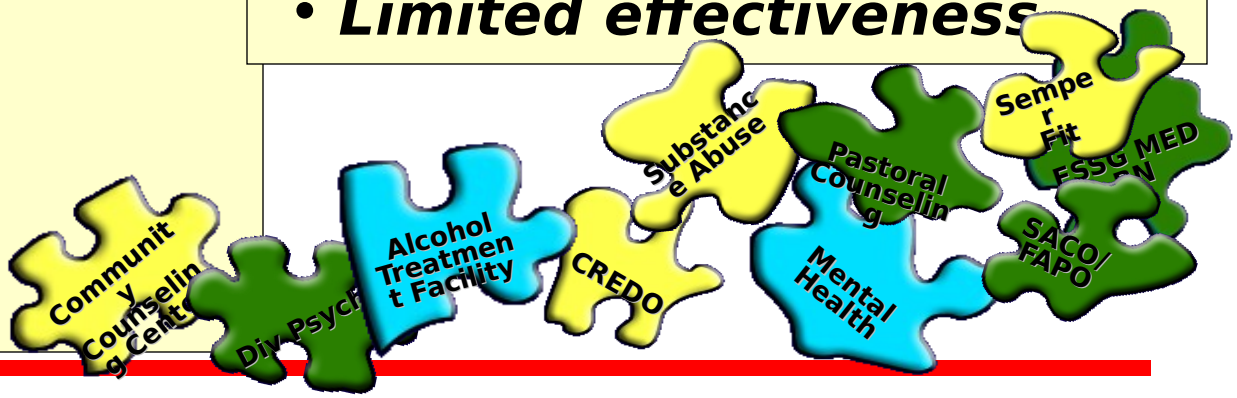
Mental Health Support in USMC (Pre-OSCAR)

FMF (Active, x3)

- Division
  - 1 Psychiatrist
  - 1 Enlisted Psych Tech
- Force Service Support Group
  - None organic
  - CSC platoon (augmentees)
    - 1 Psychiatrist
    - 2 psychologists
    - 3 psych techs
- Wing
  - None organic

MTF, MC Base MH Services

- Civilian model
  - Poorly coordinated
  - Not operationally trained
  - Non-deployable
  - Liaison/accountability to operating forces variable
  - Access problems/stigma
- *Limited effectiveness*



Putting the Pieces Together

- Multidisciplinary
- Early, coordinated intervention
- Accountable to operating forces
- Supports all phases of deployment

OSCAR Pilot

- **Expanded stress management capability at each active MARDIV**

Position	Source
1 Psychiatrist	Existing Div Billet
1 HM Psych Tech	Existing Div Billet
1 Add'l Psychiatrist	BUMED
1 Psychologist (I, II MEF)	BUMED
1 Chaplain	Division
4 SNCO's	Division

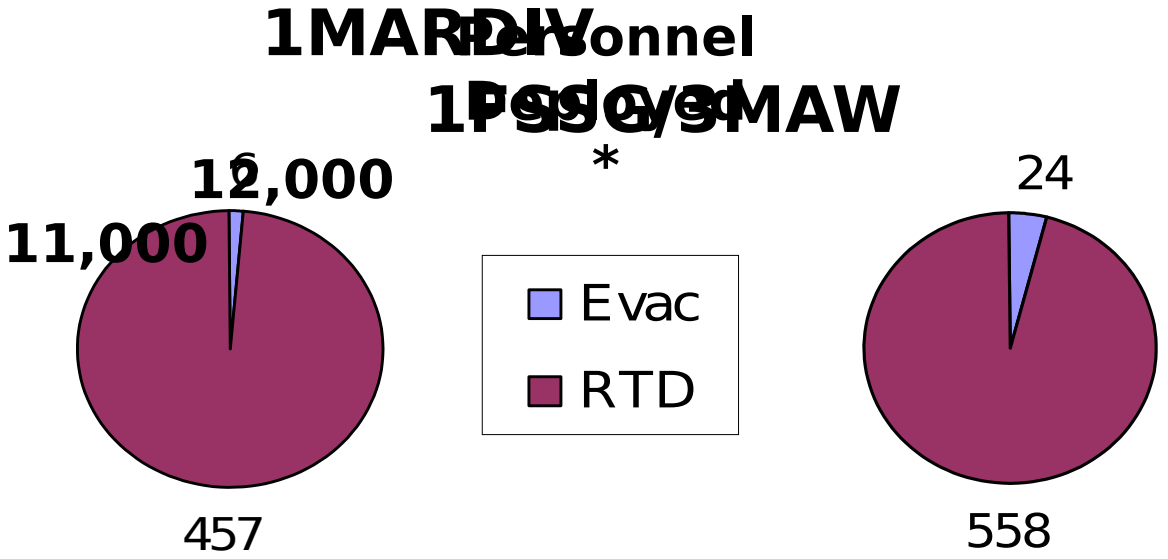
Current OSCAR Billet Status

Position	MARDIV 1st	MARDIV 2nd	MARDIV 3rd
Psychiatrist/ Team Leader*			
HM Psych Tech*			
Additional Psychiatrist			
Clinical Psychologist			
Chaplain			
Staff NCO			
Staff NCO			
Staff NCO			
Staff NCO			

*Pre-OSCAR T/O

Key	
	Filled – In Garrison
	Filled – Deployed
	Unfilled
	No billet for pilot

Disposition of Marines Receiving Mental Health Evaluations During OIF-II



1MARDIV		1MAW
4%	Referral Rate	5%
99%	Return to Duty Rate	95%

*Approx personnel deployed at any given time. (Source: 1MARDIV Psychiatrist)

Back-Up Slides: EFCAT & IG Findings

Findings From LFCAT Mission: Factors Contributing to Success

- GCE leaders pleased with organic MH with emphasis on…
  - Resiliency
  - Forward treatment
- B CSC Platoon's support to B Surgical Company medical personnel
- Collaboration with chaplains at all levels

Findings From EFCAT Mission: Factors Hindering Success

- MAP personnel felt inadequately trained in COSC
- Conflicting clinical approaches:
  - Non-medical model: no patient role, COSR label *versus*
  - Medical model: patient role, DSM-IV diagnosis
- Presence of psychiatric technicians at ostensibly non-clinical Regimental Recuperation Center
- Ambiguity of MH and chaplain roles in warrior transition program

Findings From EFCAT Mission: Areas for Further Study

- Is there value in organic MH assets at Wing? Group?
- Would MH assets on the CSC Platoon T/O be better able to help Marines by…
  - Roving more to GCE units (as Army CSC Platoons do?) or…
  - Being shifted to augment MH assets already "embedded" within the GCE?
- Is an RRC a good idea? Better at the BN level?
- Can more be done to empower forward, non-MH assets to provide stress management?
  - MO's and corpsmen
  - Small unit leaders; peers

Peer-to-Peer Programs Being Proposed/Probed By Line Marines

- Historically, this has been the cornerstone of warfighters' stress management, but it is under-appreciated
- A peer counseling program is in use today by the Royal Marines, and is being looked at by LtGen Mattis
- Example from MAG 41 (reserve unit)
- Obvious benefits
  - High access, low stigma
  - High trust and credibility
  - Timely
- Potential role for mental health
- Help train small unit leaders and peer counselors
  - Availability for referrals (direct or via primary care)
- Problem: overlaps with plan for new Warrior Transition

Line Leadership's Desire for "Wrap-around" Approach

- Current situation
  - Many players using many approaches
  - Minimal doctrine
  - Perception of inadequate services, poorly coordinated
- Dr. Grant, a civilian psychologist has proposed to pull it all together; it is being given a close look

Back-Up Slides: PDHRA